

New Patient Information

Welcome to Nalluri Plastic Surgery. Please complete our intake sheet. Payment for the evaluation is due at the time of the visit.



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Raja Nalluri, M.D.
BOARD CERTIFIED
AMERICAN BOARD OF PLASTIC SURGERY

Last Name	First Name	MI
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Address	<input style="width: 100%;" type="text"/>	street
	<input style="width: 100%;" type="text"/>	city, state zip

Home phone	<input style="width: 100%;" type="text"/>	Work Phone	<input style="width: 100%;" type="text"/>	Ext	<input style="width: 100%;" type="text"/>
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Other phone	<input style="width: 100%;" type="text"/>	Birthdate	<input style="width: 100%;" type="text"/>	Age	<input style="width: 100%;" type="text"/>
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Insurance Provider	<input style="width: 100%;" type="text"/>	SSN	<input style="width: 100%;" type="text"/>
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Emergency Contact:			
Name/ relation	<input style="width: 100%;" type="text"/>	Phone	<input style="width: 100%;" type="text"/>

your primary care doctor	<input style="width: 100%;" type="text"/>	who/what referred you to us?	<input style="width: 100%;" type="text"/>
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Name of Policyholder (if different) _____ Birthdate of Policyholder ____/____/____
Address of Policyholder (if different than address of patient):

Relation of patient to policyholder: ___Self ___Child ___Spouse ___Other
If employed, please give address of policyholder's employer:

_____ name of company

_____ street

_____ city, state, zip

Occupation: _____



Medical Problems (check those that apply)

- high blood pressure
- previous heart attack
- previous stroke
- other medical problems: _____
- diabetes
- thyroid disease
- cancer: type _____
- high cholesterol
- arthritis
- back pain

Past Surgeries

- appendectomy
- heart surgery
- breast surgery
- other surgeries: _____
- gall bladder
- skin cancer surgery
- hysterectomy
- hernia
- back surgery
- C-section

Medications: (If you have a list with you, please give it to receptionist to copy)

Drug Allergies: _____

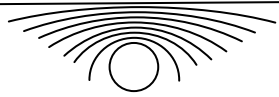
Medical Problems in blood relatives: _____

Male Female
 Single Married Widowed Divorced Other
 Employed Retired-Date: _____ Full-time Student Part-time Student

Do you smoke now: Yes No If yes, how much? _____
Past smoker? Yes No When did you quit? _____
Do you drink alcohol Yes No rarely If yes, how much? _____

Review of Systems: please check if you have any of the following:

- weight changes
- double vision
- chest pain
- wheezing
- difficulty swallowing
- feelings of depression
- incontinence
- cramps in legs while walking
- weakness in one arm or leg
- easy bleeding or bruising
- fatigue
- wear glasses
- shortness of breath with light activity
- black or bloody stools
- spontaneous awakening at 3-4 am
- need to wake up more than 2X to urinate
- arthritis
- numbness in one arm or leg
- hoarseness of voice
- shortness of breath that awakens you



Notice of Privacy Practices and Patient Authorization

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The privacy of your medical information is important to us. It is our legal duty to inform you that your medical records have always been kept confidential and our efforts are to continue. We have the right to change our privacy practices and terms of this notice at any time, provided the changes are permitted by law. In our continuing efforts to protect your privacy, we will notify you of any changes in the laws as they become effective.

Your medical records are used for the following purposes:

- a) Treatment: Your medical information is used to treat you. Medical information may be disclosed about you to doctors, nurses, technicians, medical students or others who are taking care of you. Medical information may be shared about you to your other health care providers to assist them in treating you.
- b) Payment: Medical information may be disclosed for payment purposes.
- c) Healthcare operations: Medical information may be used for quality assurance; ie audit of medical records by insurance companies, or state boards.
- d) We will use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, X-ray or medical information for you.
- e) Court orders: We may disclose your information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.
- f) Workers Compensation: Health information may be used **when authorized** and necessary to comply with laws related to workers compensation or other similar programs.

Patient Rights:

You have the right to get copies of your medical records in the format of photocopies. If you request copies we will charge you administrative time and postage, if you want the copies mailed. You have the right to request additional restrictions on your medical information. You have the right to request we change your medical information. You must make your requests in writing.

Authorization:

This form also confirms your authorization to use or disclose your protected health information for a special purpose. This form serves as an authorization and release to the medical doctor and delegated staff to perform diagnostic procedures and treatment necessary for proper medical care. This form also serves as an authorization and release for any information concerning my (or my child's) health care, advice and treatment to another doctor if necessary. This form also serves as an authorization and release for information regarding my (or my child's) health care, and advice provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for all Co-pays and Deductibles. I hereby authorize the delegated staff to release all information necessary to secure the payment of benefits. I understand that insurance is not a guarantee of benefits, and I am 100 % responsible for my bill if the doctor does not receive direct payment from my insurance. I give permission to keep a copy of my state issued picture identification on file. I authorize the use of this signature on all insurance submissions (if applicable). If you have any questions about this notice, or if you think we may have violated your privacy rights, please contact our office. You have the right to make a written complaint to the U.S. Department of Health and Human Services.

Initials:



We will not retaliate against anyone who files a complaint. You have the right at any time to revoke this authorization by giving written notice to the privacy officer at our office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written request. Please understand if you revoke, your insurance may contest your claim. You have the right to have a copy of this form after you sign.

I also authorize Dr. Raja Nalluri and assistant(s) to send my medical records to the American Board of Plastic Surgery.

I authorize Dr. Raja Nalluri and assistant(s) to take photographs and/or video for the purpose of documentation and surgical planning. I understand that the photographs will become a part of my medical record and will be treated with strict confidentiality. In addition, I authorize the use of these photographs for review by my existing physicians or physicians I am referred to and also for:

Initials:

- _____ review by other patients
- _____ publication in medical journals
- _____ advertisement

Signature

Date

Name (Print)

I authorize my medical and/or financial information to be shared with the following person(s):

Name

Relation

Name

Relation